

Analysis of out-of-pocket expenditures in the Philippines

*Valerie Gilbert Ulep and
Nina Ashley Dela Cruz*

Despite the rosy picture of the domestic economy, income and social inequalities still persist. Basic social provisions like health care remain generally inaccessible among the vulnerable segments of the population. Although social safety nets are in place to facilitate access (e.g., social health insurance and supply-side financing mechanisms), out-of-pocket (OOP) expenditures remain to be the major source of financing during health-care episodes. For instance, OOP accounted for more than 50 percent of the total health expenditures in 2011 (NSCB n.d.).

The level of OOP is an important indicator of an effective health-care system. Ideally, an optimal health-care system should pacify the irrational growth in health expenditures. It should also have the capacity to provide

equitable financial protection, substantially reducing the amount that people pay for medical expenses. Heavy reliance on OOP may lead the population to forgo or delay seeking for care, or worst case, impoverishment.

Total health expenditures

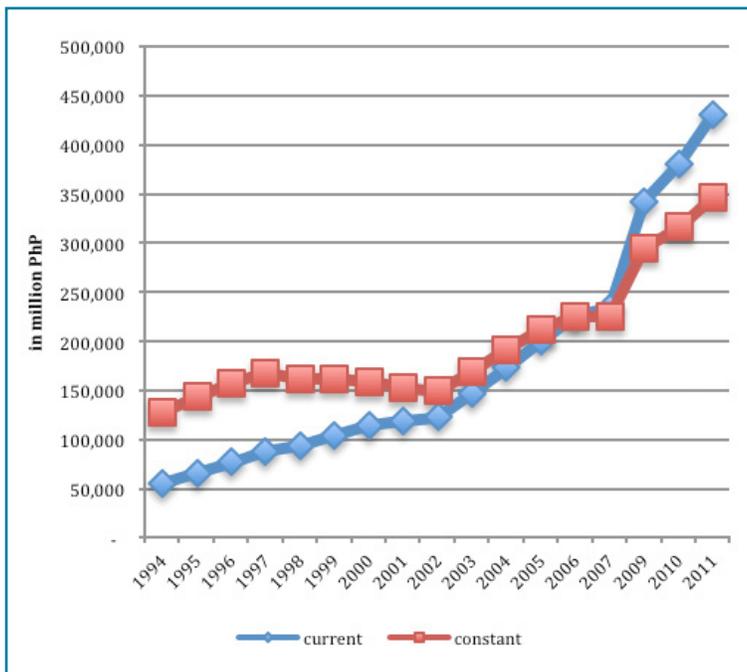
The total health expenditure is the sum of private and public spending on health. The Philippine National Health Accounts disaggregates this by major sources, namely, (1) government health expenditures (national and local), (2) social insurance, (3) private sources, and (4) others. Private sources can be further disaggregated into OOP, private

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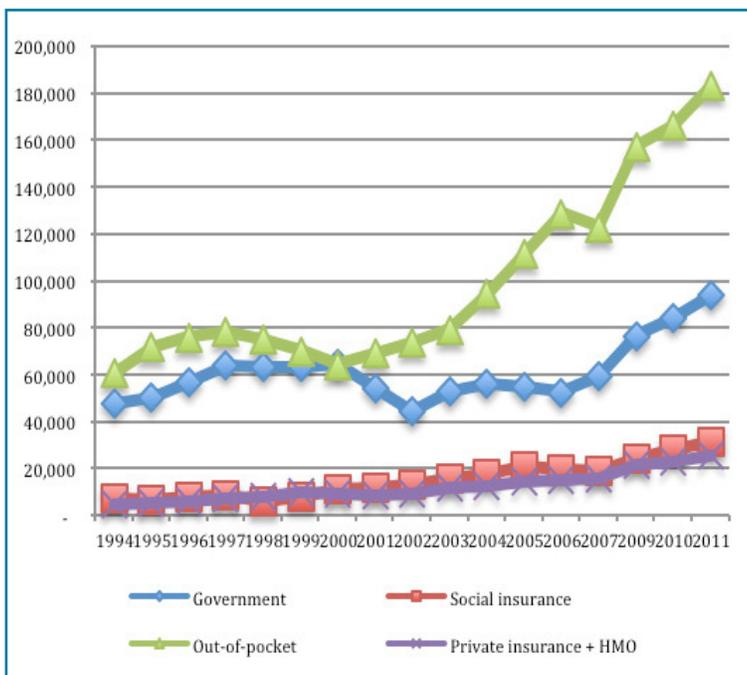
The authors are Valerie Gilbert Ulep and Nina Ashley Dela Cruz, formerly supervising research specialist and research analyst II at PIDS, respectively. The views expressed in this *Policy Note* are those of the authors and do not necessarily reflect those of the PIDS or the DOH.

Figure 1. Total health expenditure, Philippines, 1991–2011



Source: NSCB (various years)

Figure 2. Sources of health expenditure, Philippines, 1994–2011



Source: NSCB (various years)

insurance, health maintenance organizations, private establishments, and private schools.

Total health expenditure in the Philippines is increasing both in nominal and constant terms. In constant terms, there has been an increase by more than two folds in the last 12 years, from PHP 159 billion to PHP 347 billion. A rapid increase is noticeable especially the latter years of the decade (Figure 1).

All the major sources of health expenditures have increased over the last decade. Despite the significant rise in government and social insurance spending, OOP health expenditure remains the major source, which accounts for more than 50 percent of the total health expenditures. From 1991 to 2011, the average annual growth rates for government, social insurance, OOP, and private insurance were 3.9 percent, 8.5 percent, 6.3 percent, and 9.5 percent, respectively. According to the Department of Health (2012), the country targets to decrease the share of OOP by less than 50 percent and increase the share of social health insurance by 2016 (Figures 2 and 3).

Out-of-pocket expenditures

Operationally, OOP is defined as “any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of

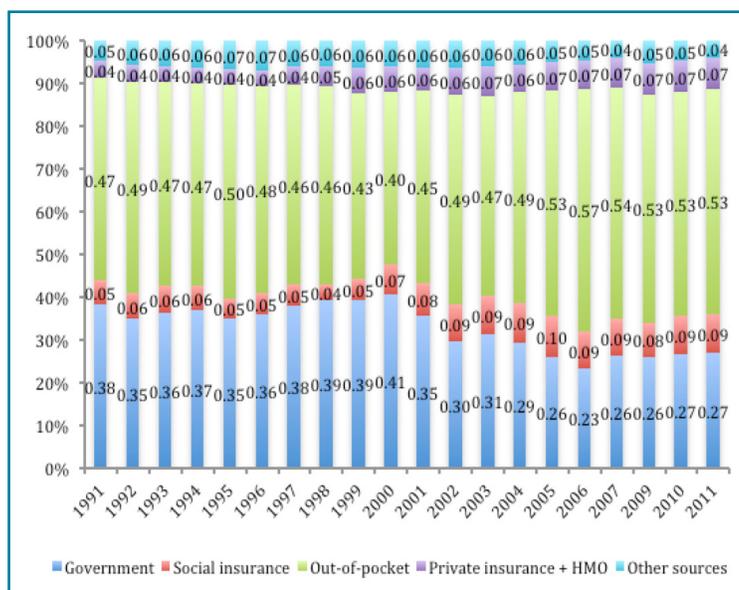
individuals or population groups. It is a part of private health expenditure” (WB n.d.).

The average household OOP expenditure has increased over the years, both in nominal and constant terms (Table 1). The average household OOP expenditure had increased by 21 percent (using constant term) from 2009 to 2012, a more rapid growth compared to the rate from 2006 to 2009.

OOP health expenditure has a positive relationship with socioeconomic status. Over the years, the average household OOP expenditure has increased in all socioeconomic quintile groups. However, households in the lower income groups (Q1 and Q2) have posted a relatively higher annual growth rate in the latter part of the last decade. The increase in OOP among the lower income groups might be attributed to the increasing health-care demand. However, this should be validated with health-care utilization patterns.

Although the growth rate of health expenditure has increased across income groups, OOP remains to be inequitable. In 2012, almost 80 percent of the total OOP came from Q4 and Q5 households, and only 10 percent from Q1 and Q2. The important policy question of unnecessary health-care expenditures and overutilization of medical care among the richer segments remain to be relevant. The lack of ineffective policy and regulatory instruments that directly and indirectly control health expenditure in

Figure 3. Sources of health expenditures, Philippines, 1991–2011



Source: Family Income and Expenditure Survey (FIES), various years (NSCB)

Table 1. Average household OOP health expenditures, Philippines, 2000–2012

Year	Constant (2006)					
	Q1	Q2	Q3	Q4	Q5	National
2000	416	862	1,539	3,053	9,785	3,131
2003	445	967	1,665	3,106	8,633	2,961
2006	506	1,083	2,054	3,807	13,516	4,193
2009	547	1,131	2,091	4,217	13,050	4,207
2012	1,075	1,889	3,001	6,422	15,029	5,483
AGR*	37	30	25	28	15	21

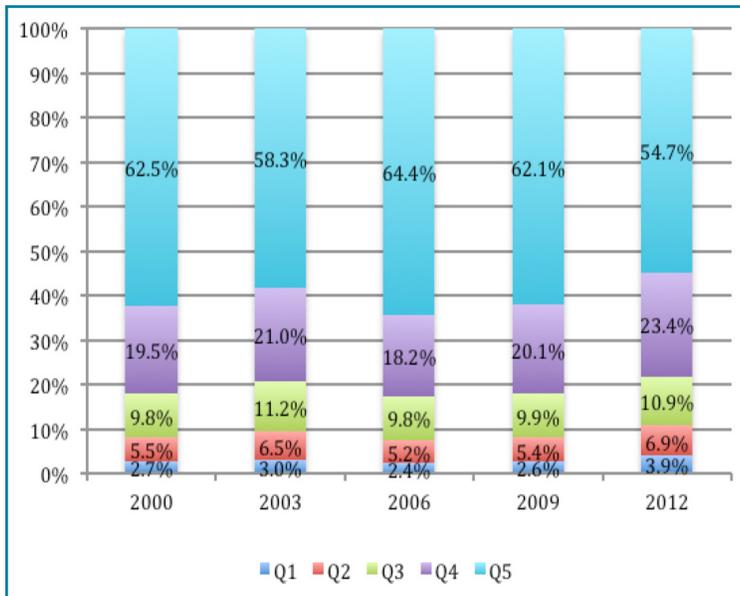
* Annual growth rate from 2009 to 2012 (in %)

Note: Consumer price index for health was used to adjust current to constant prices.

Source: Analysis of FIES

All the major sources of health expenditures have increased over the last decade. Despite the significant increase in government and social insurance spending, OOP health expenditure remains the major source, which accounts for more than 50 percent of the total health expenditures.

Figure 4. Share of OOP in health expenditure by quintile groups, Philippines, 2000–2012



Source: Analysis of FIES

Table 2. Aggregates of household OOP health expenditures, Philippines, 2012

Components	Quintile 1		Quintile 5		National	
	Average Expenditure	Share (in %)	Average Expenditure	Share (in %)	Average Expenditure	Share (in %)
Medical products	514.6	59	10,189.6	46	3,415.1	49
Pharma products	329.7	64	6,597.6	65	2,191.9	64
Nutritionals	148.5	29	2,934.3	29	997.7	29
Other medical preparations	20.1	4	304.7	3	107.8	3
Other medical products	11.9	2	129.2	1	48.9	1
Therapeutic appliance	4.4	1	223.8	2	68.8	2
Outpatient services	113.7	13	3,876.2	17	1,101.0	16
Medical services	86.9	76	3,224.2	83	917.8	83
Dental services	3.3	3	366.0	9	89.5	8
Paramedical services	23.5	21	286.1	7	93.7	9
Inpatient services	242.2	28	8,271.0	37	2,519.0	36
Public	179.7	74	1,104.4	13	664.1	26
Private	62.4	26	7,166.6	87	1,854.9	74

Source: FIES

richer segments may not lead to decrease in the total value of OOP (Figure 4).

Dissecting the components of OOP

Analyzing the aggregates of OOP health expenditures can demonstrate (1) unnecessary health expenditures and (2) overutilization and underutilization of goods and services. Table 2 shows medicines as the major source of OOP in 2012. Although the average household OOP expenditure for medical products is positively correlated with the socioeconomic status, the share to total OOP health expenditure is negatively correlated (Q1: 59 vs. Q5: 49%). This trend is noticeably different from the share of expenditures brought by seeking a health provider (inpatient and outpatient services).

Despite their higher risk of diseases, the poorest quintiles tend to spend less on inpatient and outpatient care relative to their total OOP health expenditures. This scenario may suggest the heavy reliance of poor households on medicines during health-care episodes in lieu of actual visit to a health facility. The assumption of forgoing care and unnecessary utilization of medical products should be validated with more empirical evidence.

Burden of health payments

Burden of health payment is defined as the share of OOP expenditure on health on household capacity to pay (Xu 2005). Capacity to pay is defined as the nonsubsistence effective income of the household. In Table 3, it can be observed that the burden of health payment had risen from 1.8 percent in 2000 to 4.8 percent in 2012.

Burden of health payments is positively correlated with the socioeconomic status. In other words, the higher burden of health payments is occurring in richer quintiles. This is expected as the demand for care is higher among the rich. From 2000 to 2009, there had been a stagnation in the burden of health payments in lower income quintiles (Q1 and Q2). However, a significant increase had been noted from 2009 to 2012.

A household is said to have incurred catastrophic payments if the burden of payments (i.e., OOP/income) exceeds a specified threshold (Xu 2005). The World Health Organization uses 40 percent as threshold when “capacity to pay” (roughly, total expenditure minus food) is used as the denominator (Xu 2005, p3).

There has been an increasing trend of catastrophic health payments over time. The proportion of households that incur catastrophic payments had risen from 0.49 percent in 2000 to 1.5 percent in 2012. This translates to roughly 1.5 million people spending more than 40 percent of their earnings on health care.

Table 3. Share of out-of-pocket on capacity to pay (in percent)

Quintile Groups	2000	2003	2006	2009	2012
Q1	2.4	2.8	3.0	3.0	4.0
Q2	2.8	3.1	3.4	3.5	4.5
Q3	2.9	3.2	3.8	3.7	4.6
Q4	2.8	2.8	4.0	4.1	5.3
Q1	3.0	3.0	4.2	4.6	5.5
Philippines	2.8	3.0	3.7	3.8	4.8

Source: Based on authors' calculation of various rounds of FIES

Table 4. Impoverishment indicators

Indicators	2000	2003	2006	2009	2012
Headcount pre-OOP (in %)	23.1	19.2	19.8	18.4	19.4
Headcount post-OOP (in %)	23.7	19.9	20.6	19.2	20.4
Percent of impoverished households	0.6	0.7	0.9	0.8	1.0
Poverty gap before OOP	231.8	191.8	222.0	240.6	282.1
Poverty gap after OOP	239.1	199.4	232.7	252.6	299.7
Difference	7.2	7.5	10.7	12.0	17.5

Source: Analysis of FIES 2000–2012

Impoverishment

In the extreme, OOP payments could lead to poverty. Looking at Table 4, around 18 percent of the population are living in poverty, defined as total expenditure being lower than the subsistence spending. If OOP payments for health care are netted out, this percentage rises to 19.4 percent. Thus, 1 percent of the population become poor once health expenditure occurs. The poverty gap also increases from PHP 282 to PHP 300 (Table 4).

Moving forward

This study on OOP confirms the following:

- OOP continues to rise despite the enormous programmatic and fiscal investments in recent years.
- Health-care demand is increasing as manifested by the increasing average household OOP health expenditures in all quintiles over the years (both in nominal and constant terms).
- The prevalence of catastrophic payments and incidence of impoverishment due to OOP are increasing.
- Drugs continue to be the major source of OOP expenditure.
- There is a compelling evidence of underutilization and overutilization of health-care services and goods.

The following policy recommendations are then suggested:

- Expand the benefit packages of Philippine Health Insurance Corporation (PhilHealth) especially on outpatient

medicines. The expansion should not be limited to the Sponsored Program, as selective benefit coverage losses the power of PhilHealth as the main purchaser. However, it should ensure that benefits are cost effective and necessary.

- Strengthen the provider payment mechanisms (PPM) of PhilHealth. PPM is a powerful tool in controlling and stimulating the behaviors of consumers (patients) and health-care providers. Strategic PPM can optimize health-care utilization; therefore rational growth in health care expenditures is expected.
- Continue the movement to expand coverage especially of nonpoor informal workers, which is now the battleground sector in achieving full coverage.

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For further information, please contact

The Research Information Staff
 Philippine Institute for Development Studies
 18th Floor, Three Cyberpod Centris - North Tower
 EDSA corner Quezon Avenue, Quezon City
 Telephone numbers: (63-2) 372-1291 and 372-1292
 E-mail: publications@mail.pids.gov.ph

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